Supreme Court, U.S.
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No. 06-915

IN THE

Supreme Court of the United States

JAMES MCDONALD AND KAREN MCDONALD,
PETITIONERS

v.

HSBC FINANCIAL CORPORATION, AND UNITED HEALTHCARE CORPORATION D/B/A UNITED HEALTHCARE INSURANCE COMPANY

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

I. Whether a plaintiff who has suffered personal injury should be allowed to pursue "make-whole" relief, consisting of lost wages and impaired earning capacity, against a fiduciary whose violation of an ERISA benefit plan has contributed to cause that plaintiff's damage?

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The order of the United States District Court of the Southern District of Indiana, Indianapolis Division, denying Defendants' HSBC Finance Corporation's ("HSBC") and United Healthcare Corporation's d/b/a United Healthcare Insurance Company ("United Healthcare") 12(B)(6) Motion to Dismiss is reproduced at Appendix 3. The district court denied Defendants' motion to reconsider, and certified the preceding question for interlocutory appeal, pursuant to 28 U.S.C. §1292(b). (App. 13).

The order of the United States Seventh Circuit Court of Appeals denying HSBC's and United Healthcare's Petition for Permission to Appeal the district court orders is reproduced at App. 1

JURISDICTION

The order of the Seventh Circuit Court of Appeals was entered on October 5, 2006. (App. 1). This Court has jurisdiction under 28 U.S.C. §1254(1).

RELEVANT PROVISIONS

ERISA § 502, 29 U.S.C. § 1132, is reproduced at App. 17

STATEMENT

A. Statement of Facts

On November 19, 2001, Plaintiff James McDonald began employment with HSBC. (App. 30,

Complaint ¶ 6). Prior to his employment with HSBC, Mr. McDonald had been prescribed Vasotec, a prescription medication for his high blood pressure. (App. 31, Complaint ¶ 11). Incident to his acceptance of employment, Mr. McDonald was promised insurance coverage, including prescription benefit coverage, through HSBC's group insurance plan, United Healthcare. (App. 30-31, Complaint, ¶ 7). Pursuant to Mr. McDonald's November 16, 2001 Employment Confirmation Letter, his insurance coverage was to be effective December 19, 2001, thirty days from his start date of November 19, 2001. (App. 31, Complaint ¶ 10).

After the promised effective date of December 19, 2001, Mr. McDonald made repeated attempts to get prescriptions filled, including his Vasotec high blood pressure medication, and was told that the paperwork had not come through and he had no benefits to cover his prescribed medication, Vasotec. (App. 31, Complaint ¶ 12). Unable to pay for the Vasotec without insurance coverage, Mr. McDonald made repeated requests to HSBC and to United regarding his insurance benefit coverage, pleading for it to be activated. (App. 31-32, Complaint ¶¶ 13, 14). HSBC and United, however, did not procure nor provide the promised insurance, and James McDonald continued to be deprived of necessary medication, specifically anti-hypertensive Vasotec. (App. 31, Complaint ¶¶ 12, 13). On January 15, 2002, nearly one month after his insurance coverage was to have become effective, Plaintiff, James McDonald suffered a catastrophic hypertensive intercerebral hemorrhagic stroke. (App. 32, Complaint ¶ 15).

HSBC and United individually and jointly owed Mr. McDonald, fiduciary obligations related to the

promised ERISA benefits and breached those obligations by failing to procure insurance coverage as promised in the Employment Confirmation Letter and as set forth in the Plan. (App. 32, Complaint ¶¶ 17, 18). As a result of HSBC's and United's breach of fiduciary obligations, Mr. McDonald suffered a catastrophic hypertensive intercerebral hemorrhagic stroke leaving him unable to work and provide for his family. (App. 32, Complaint ¶¶ 15, 20).

B. Court Proceedings

Diversity jurisdiction was established pursuant to 28 U.S.C. §1332 for review by the United States District Court of the Southern District of Indiana, Indianapolis Division. The McDonalds filed their initial complaint on November 14, 2003 alleging that HSBC and United Healthcare were liable under state law theories of negligence and breach of contract. HSBC and United Healthcare filed their first 12(B)(6) Motion to Dismiss claiming that ERISA preempted state law claims. The District Court granted the Motion to Dismiss. The McDonalds appealed the District Court's dismissal to the Seventh Circuit Court of Appeals. The Seventh Circuit, while holding that ERISA preempted state law, reversed and remanded, inviting the McDonalds to bring their claims against HSBC and United Healthcare under ERISA's provisions for relief. *McDonald v. Household International, Inc.*, 425 F.3d 424, 429-30 (7th Cir. 2005).

The McDonalds filed a second amended complaint on January 6, 2006 seeking "make-whole" relief under ERISA. HSBC and United Healthcare filed their second 12(B)(6) Motion to Dismiss. (App. 29). The Motion to Dismiss claimed that monetary awards in the amount of lost wage and impaired earning capacity did not qualify as the recoverable "equitable relief" authorized by § 502(a)(3) of ERISA. The District Court denied HSBC's and United Healthcare's second 12(B)(6) Motion to Dismiss as to Mr. McDonald's ERISA claim. (App. 11). The court held that Mr. McDonald's second amended complaint sought an equitable recovery under ERISA § 502(a)(3) which would compensate for lost wages and impaired earning capacity. (App. 11). As to Mrs. McDonald's ERISA claim, the court granted HSBC's and United Healthcare's Motion to Dismiss. The court found that Plaintiffs' complaint set forth no factual basis to support Mrs. McDonald's standing to bring a claim under ERISA. (App. 11).

HSBC filed a Motion to Reconsider, and United Healthcare filed a Motion for Certificate of Appealability. The McDonalds joined in United Healthcare's motion seeking permission to appeal to the Seventh Circuit. The District Court denied HSBC's Motion to Reconsider and certified the case for appeal pursuant to 28 U.S.C. § 1292(b). (App. 13-16). HSBC and United Healthcare filed their Petitions for Permission to Appeal with the Seventh Circuit. The Seventh Circuit, without explanation, denied the Petitions. (App. 1-2).

REASONS FOR GRANTING THE PETITION

I. Whether a plaintiff who has suffered personal injury should be allowed to pursue "make-whole" relief, consisting of lost wages and impaired earning capacity, against a fiduciary whose violation of an ERISA benefit plan has contributed to cause that plaintiff's damage?

The question presented by the McDonalds was certified by the United States District Court for the Southern District of Indiana pursuant to 28 U.S.C. § 1292(b) as a controlling question of law unresolved by the Seventh Circuit, and by this Court. (App. 13-16). The McDonalds, HSBC, and United Healthcare were in agreement that the issue should be certified for interlocutory appeal. However, with the Seventh Circuit's denial of the Petitions for Permission to Appeal, the McDonalds now respectfully petition this Court to review the question presented by the District Court.

The question of what "make whole" relief is available under ERISA arises from § 502(a)(3), 29 U.S.C. § 1132(a)(3) which states as follows:

> (a) Persons empowered to bring a civil action
> A civil action may be brought-
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violate any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce

> any provisions of this subchapter or the terms of the plan.

(App. 17). Mr. McDonald exclusively relies upon § 502(a)(3) as the basis for make-whole relief, consisting of lost wages and impaired earning capacity, from HSBC's and United Healthcare's breach of fiduciary duties.

The District Court in denying HSBC's and United Healthcare's Motions to Dismiss pursuant to Fed. R. Civ. P. 12(b)(6), recognized its ruling's apparent conflict with *Coan v. Kaufman*, 457 F.3d 250 (2nd Cir. 2006) and *LaRue v. DeWolff, Boberg & Associates, Inc.*, 450 F.3d 570 (4th Cir. 2006). (App. at 14). Nevertheless, the District Court persisted in its opinion that Mr. McDonald had stated a claim upon which relief could be granted. (App. at 14-16). While the McDonalds agree with, and hope to defend, the District Court's ruling concerning the viability of Mr. McDonald's claim, they also recognize the conflict and continued debate surrounding what "equitable relief" is available under § 502(a)(3).

As the law currently stands, there is conflict and confusion among the Circuit Court of Appeals surrounding what equitable relief is available under § 502(a)(3). *Coan* and *LaRue* both examined *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S.Ct. 1869 (2006) and rejected the plaintiffs' claim for make-whole relief under § 502(a)(3) because the claims sought monetary relief. *Coan*, 457 F.3d at 263-64; *LaRue*, 450 F.3d at 575-77. Prior to *Sereboff*, other Circuits found that relief under § 502(a)(3) does not encompass money damages. *Calhoon v. Trans World Airlines, Inc.*, 400

F.3d 593, 598 (8th Cir. 2005); *Peralta v. Hispanic Business, Inc.*, 419 F.3d 1064, 1076 (9th Cir. 2005); *Callery v. U.S. Life Ins. Co. in the City of N.Y.*, 392 F.3d 401, 408-09 (10th Cir. 2004); *Helfrich v. PNC Bank, Kentucky, Inc.*, 267 F.3d 477, 482 (6th Cir. 2001) ("ERISA does not permit plan beneficiaries to claim money damages from plan fiduciaries.")

Admittedly, the District Court's ruling in favor of Mr. McDonald is in clear conflict with the post-*Sereboff* opinions of *LaRue* and *Coan*, and may also conflict with those pre-*Sereboff* opinions as cited above. The District Court's reluctance to follow other Circuits' positions stems from the Seventh Circuit's acceptance of Justice Ginsburg's concurring opinion in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 223 (2004), as a potential avenue for "make-whole" relief. *McDonald v. Household International, Inc.*, 425 F.3d 424, 429-30 (7th Cir. 2005); (App. 9-12). After finding that the McDonalds' state law claims were preempted, the Seventh Circuit in *McDonald* encouraged Mr. and Mrs. McDonald "to take note of Justice Ginsburg's comment in her concurring opinion in *Davila*." *Id.* at 430.

The Seventh Circuit's allusion in *McDonald* that there may be some make-whole relief available under § 502(a)(3), is further substantiated by the Seventh Circuit's repeated award of ERISA monetary relief, albeit in slightly different circumstances than presented by the McDonalds' case. The Seventh Circuit recognized the equitable nature of a monetary award against a breaching fiduciary in *Bowerman v. Wal-Mart Stores, Inc.*, 226 F.3d 574 (7th Cir. 2000). Then, in *Brosted v. Unum Life Ins. Co. of America*, 421 F.3d 459, 466 (7th Cir. 2005) the Seventh Circuit confirmed

Bowerman's conclusion that monetary relief is available in an equitable action brought under § 502(a)(3). Thus, the Seventh Circuit's position allowing monetary equitable relief under § 502(a)(3) appears to be in conflict with *LaRue* (4th Cir.) and *Coan* (2nd Cir.).

Nevertheless, presented with the Parties' Petition for Permission to Appeal the Seventh Circuit has, somewhat surprisingly, passed on the opportunity to further clarify their position on § 502(a)(3). An appellate court may deny an appeal under § 1292(b) for any reason, including docket congestion. *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 475 (1978). However, the Seventh Circuit's refusal to issue an opinion may be more connected to its reluctance to "wade into this morass" of caselaw surrounding equitable relief under § 502(a)(3). *Brosted*, 421 F.3d at 466.

It is this "morass" which has led to what Justices Ginsburg and Breyer refer to as a "regulatory vacuum." *Davila*, 542 U.S. at 222. The District Court called it a "Catch 22." (App. 3). The McDonalds first exhausted all possible state law remedies, were then encouraged by the Seventh Circuit to explore the available remedies under ERISA § 502(a)(3), and now face the argument that no meaningful remedy exists under ERISA as well. This in spite of the well recognized fact that ERISA was designed to protect the interests of employees such as Mr. McDonald. *Anweiler v. American Elec. Power Service Co.*, 3 F.3d 986, 989-90 (7th Cir. 1993) (quoting 29 U.S.C. § 1001(b)). ERISA's objective of protecting Mr. McDonald's interests by holding HSBC and United Healthcare to a standard which recognizes their fiduciary obligations to Mr. McDonald is of great

national importance. For if HSBC and United are held to no standard of responsibility for employer and plan administration, then the very reason for ERISA's creation is rendered meaningless. Those such as HSBC and United would be free to activate employee insurance coverage at their own whim or ineptitude, without any realistic equitable recourse for the countless beneficiaries subject to HSBC's and United's control and authority over plan benefits.

Sufficient grounds for this Court's review is found in the conflict and confusion among the Circuit Court of Appeals surrounding what equitable relief is available under § 502(a)(3). The McDonalds respectfully request that this Court accept jurisdiction of this controlling and contested issue of law, and affirm the District Court's opinion. An opinion concluding that Mr. McDonald can seek an equitable recovery under ERISA § 502(a)(3) which would include monetary relief for lost wages and impaired earning capacity. (App. 11).

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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(any footnotes trail end of each document)

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604
October 5, 2006 *Before*

Hon. FRANK H. EASTERBROOK, Circuit Judge
Hon. DIANE P. WOOD, Circuit *Budge*
Hon. DIANE S. SYKES, *Circuit Judge*

IN RE
UNITED HEALTHCARE CORPORATION,doing business as UNITED HEALTHCARE INSURANCE COMPANY, Petitioner.
No. 06-8028

IN RE
HSBC FINANCE CORPORATION Petitioner,
No,06-8030

APPEAL FROM THE UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF INDIANA INDIANAPOLIS DIVISION

NO. 03-C-1698

Judge Richard L. Young

The following are before the court:

1. UNITED'S PETITION FOR PERMISSION TO APPEAL, filed on September 27, 2406, by counsel for the petitioner in appeal no. 06-8428.

2. HSBC FINANCE CORPORATIOMS PETITION FOR PERMISSION TO APPEAL, filed on October 2, 2006, by counsel for the petitioner in appeal no. 06-8034.

IT IS ORDERED that #1 and #2 are DENIED.

Filed 8/1/06

1:03-cv-1698-RLY-TAB

UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF INDIANA INDIANAPOLIS DIVISION

JAMES MCDONALD and KAREN MCDONALD,
Plaintiffs,

vs.

HSBC FINANCE CORPORATION and UNITED HEALTHCARE CORPORATION d/b/a UNITED HEALTHCARE INSURANCE COMPANY,
Defendants.

ENTRY ON DEFENDANTS' MOTIONS TO DISMISS

Having already successfully pursued the dismissal of Plaintiffs' state law claims on the basis of preemption under the Employee Retirement Income Security Act ("ERISA"), Defendants now attempt to complete the invocation of what amounts to a "Catch 22 "[1] by having this court dismiss Plaintiffs' ERISA claim for failure to state a claim upon which relief can be granted. For the reasons discussed in this entry, the court will not dismiss the Complaint, but will dismiss the claim of Karen McDonald as she has pled no facts which would give her standing to pursue the ERISA claim set forth in the Complaint.

I. Factual Background

James McDonald began working for HSBC Financial Corporation ("HSBC") on November 19, 2001, at its Carmel, Indiana office. He was informed in writing that he would receive a benefits package that included prescription benefit coverage and that this coverage would be effective 30 days from his start date. Under the benefit plan, McDonald was responsible for certain premium payments made through payroll deductions and then would only pay a small co-payment at the time he procured any prescribed drug at a retail pharmacy. The premium payments were deducted from McDonald's pay check; however, when he sought to utilize the prescription benefits after 30 days on the job, he was told that he was not listed as having benefits under the HSBC plan.

McDonald had a prescription for Vasotec, a blood pressure medication, since before he started work at HSBC. After the 30-day waiting period following his start date with HSBC he went to a pharmacy to fill his Vasotec prescription, but was unable to obtain it because he was not listed as having any benefits and could not afford to pay the full price of the prescription out of his own pocket. He made several subsequent appeals to his employer and Defendant United Healthcare Corporation ("United"), the insurer under the HSBC health benefits plan, but his benefits were not activated prior to January 15, 2002, the date McDonald suffered a catastrophic hypertensive stroke. McDonald claims he did not take his mediation because he was unable to afford to purchase it without his prescription benefits. Subsequent to his stroke, McDonald's status as a beneficiary of the HSBC

employee benefit plan was confirmed and his further requests for health benefits associated with his medical expenses have been paid.

McDonald and his wife, Plaintiff Karen McDonald, filed their first complaint in this lawsuit, setting forth six counts against HSBC and United, including breach of contract, negligence, loss of consortium and other state law theories of recovery. They sought to invoke the court's diversity jurisdiction. This court granted the Defendants' motions to dismiss on the basis of ERISA preemption, but commented that Plaintiffs were free to re-file within 30 days if they chose to pursue a claim under ERISA. The McDonald's appealed and the Court of Appeals found that their state law claims were preempted by ERISA, but that this court should have simply interpreted the facts alleged in the original Complaint as sufficient to support a claim for relief under that statute, rather than dismissing with leave to re-file. *McDonald v. Household International, Inc.*, 425 F.3d 424, 429-430 (7th Cir. 2005).

After remand, the Plaintiffs filed a Second Amended Complaint which sets forth a claim under ERISA. They assert in their brief that their claim is one under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and that it is brought against the Defendants as fiduciaries. Plaintiffs seek to recover McDonald's lost wages and damages for his impaired earning capacity in order to provide some form of "make-whole relief' under the equitable "catchall" provided in § 502(a)(3). Once more both Defendants have filed motions to dismiss, pursuant to Fed.R.Civ.P. 12(b)(6). They claim that the type of makewhole relief sought by Plaintiffs is unavailable under ERISA and that since McDonald's benefits are

now being paid, he has no further claim. In addition, one Defendant contends that Mrs. McDonald is not a participant in any benefit plan and therefore has no standing to bring a suit under ERISA.

II. Standard of Review

In reviewing a motion to dismiss under Fed. R. Civ. P. 12(b)(6), we look at the complaint in a light most favorable to the plaintiff. *Lee v. City of Chicago*, 330 F.3d 456, 459 (7th Cir. 2003). This entails accepting all well-pleaded allegations as true and drawing any reasonable inferences from them in the plaintiff's favor. Id. A motion will be granted only if it appears beyond a reasonable doubt that the plaintiff cannot prove any facts which would support a claim for relief. *Manning v. Miller*, 355 F.3d 1028, 1031 (7th Cir. 2004).

III. Discussion

Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004), has drawn the attention of the Court of Appeals and both sides in this lawsuit. It is the most recent decision from the Supreme Court which addresses some of the issues that have been raised in this case. While this case does (or did) share some common elements with *Davila*, its distinctions are noteworthy as well. In the end, it is the concurring opinion in *Davila* which most influences this court's decision not to grant the Defendant's motions to dismiss.

In *Davila*, the defendants were the insurer's which administered and provided coverage under a health maintenance organization ("HMO") which was sponsored as part of an employee health benefit plan.

One plaintiffs action was premised entirely on the refusal of defendant Aetna to approve payment for his Vioxx prescription. Id. at 211. He went without his prescribed medicine and took an over the counter alternative which caused a severe reaction and led to his hospitalization. Id. at 205. The other plaintiff sued defendant CIGNA for refusing to authorize more than a single day of hospitalization following major surgery, despite her doctor's advice and recommendation. Id. at 211. She was discharged after the single day of recovery from surgery and subsequently developed severe complications. Id. at 205. Each of these plaintiffs brought suit in Texas state court for violations of the Texas Health Care Liability Act. Id. The defendants removed the cases and the district court refused to remand the cases, finding that the claims were preempted by § 502(a) of ERISA and therefore appropriately brought to the federal courts. Id. The cases were consolidated on appeal to the Court of Appeals for the Fifth Circuit, which reversed the district court decisions, finding that the Texas law did not completely duplicate the causes of action provided in ERISA and therefore plaintiffs' causes of action, which sought tort-like damages premised upon a statutory duty external to ERISA, were not preempted. Id. at 206.

The Supreme Court reversed the Fifth Circuit in Davila, finding that ERISA preemption applied to lawsuits brought only to remedy the denial of benefits. Id. at 221. In so doing, it discussed the remedies available under § 502 (a)(1) of ERISA, as well as those that are not available. The decision reinforced the significant breadth of ERISA preemption, but also commented on the intentional limitation of remedies

under the Act, stating: "[T]he limited remedies available under ERISA are an inherent part of the `careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." Id. at 215 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 55 (1987).

It is this inherent limitation of remedies by ERISA which the Defendants in this lawsuit wish to invoke to have the court dismiss the McDonalds' claims. They would have the court view this case as a straight forward denial of benefits case where a participant is seeking extracontractual damages for consequential injuries. Such claims for monetary relief brought against fiduciaries under § 502(a)(2) of ERISA have been rejected. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). Alternatively, since the McDonalds' have stated that their claims are brought for equitable relief pursuant to § 502(a)(3), Defendants point to the fact that § 502(a)(3) has been interpreted as not authorizing an award of money damages against a non-fiduciary. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). Then, in hopes of closing the door to § 502(a)(3) claims for monetary damages against fiduciaries as well, Defendants argue that neither *Great-West* nor *Mertens* made any attempt to distinguish fiduciaries from non-fiduciaries and the analysis of those cases should apply to fiduciaries as well. Defendants also contend that to the extent there was a failure to add McDonald to the benefit plan, such an action was merely ministerial and therefore not a fiduciary responsibility.

First, the court notes that this case is not pled as a § 502(a)(2) claim, so *Russell is* inapplicable. Second, this matter is at the pleading stage and there is no evidence of record yet as to what caused McDonald not to be on the list of those entitled to coverage under the benefit plan. Under ERISA a fiduciary is defined as a person who exercises discretionary authority with respect to the administration of the plan, the management of plan assets or offers investment advice for a fee with respect to plan property or assets. 29 U.S.C. § 1002(21). At this point it is impossible to know whether the failure to list McDonald as a covered employee was intentional, a mistake or the result of inaction. Nor can it be said with any assurance that it was the responsibility of a particular person or entity, fiduciary or otherwise. These are questions of fact and the latter is an important one; at least Justice Ginsburg and Judge Wood have hinted as much.

In her concurring opinion in *Davila*, Justice Ginsburg discussed the amicus brief supplied by the United States and wrote:

> A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief.
>
> ***
>
> As the array of lower court cases and opinions document, fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order.
>
> ***

> The Government notes a potential amelioration. Recognizing that "this Court has construed Section 502(a)(3) not to authorize an award of money damages against a *non-fiduciary*," the Government suggests that the Act, as currently written and interpreted, may "allo [w] at least some forms of 'make-whole' relief against a breaching *fiduciary* in light of the general availability of such relief in equity at the time of the divided bench."

Davila, 542 U.S. at 223 (citations omitted). Justice Ginsburg went on to note that in that case the plaintiffs had declined the opportunity to amend their complaints to state a claim for relief under § 502(a) and therefore their suits were properly dismissed. However, she added that the suggestion made by the Government "might indicate an effective remedy others similarly circumstanced might fruitfully pursue. In the course of remanding this case, Judge Wood observed in her opinion that the McDonalds "may wish to take note of that part of Justice Ginsburg's concurring opinion in *Davila* which is quoted above. *McDonald*, 425 F.3d at 430.

This court is mindful that ERISA case law has developed a rather deep line of precedent which interprets the intent of Congress as severely limiting available remedies for protection of participants, including equitable remedies under § 502(a)(3), so as to strike a balance which still promotes a policy favoring the adoption of benefit plans by employers. The efficacy of that precedent has also sparked a debate amongst jurists, practitioners and academicians which Justice Ginsburg referred to when she agreed with the

majority position in *Davila*, but stated: "... I also join the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime." *Davila*, 542 U.S. at 222. (citation omitted). However, this court's decision today is not dependent on a revisitation. The likelihood that Plaintiffs will establish facts that might allow their case to squeeze past the existing limitations on ERISA's equitable remedy may be remote, but without the benefit of an evidentiary record, the court can not say that it is impossible.

There is a line of argument advanced by HSBC that does have unquestionable merit. Plaintiff, Karen McDonald, first sought recovery through a derivative state law claim. As the Seventh Circuit noted, Plaintiffs' state law claims are preempted. The Second Amended Complaint, filed after the case was remanded, seeks an equitable recovery under ERISA § 502(a)(3) which would compensate for Mr. McDonald's lost wages and impaired earning capacity. The Second Amended Complaint sets forth no factual basis to support Mrs. McDonald's standing under ERISA, nor does it set forth any allegations that would support her recovery under any legal theory. Consequently, her claim is dismissed and the case will proceed with Mr. McDonald as the only Plaintiff. IV. Conclusion

For the reasons discussed in this entry, Defendant HSBC's Motion to Dismiss the Second Amended Complaint (Document # 71) is GRANTED IN PART, insofar as the claims of Plaintiff Karen McDonald are dismissed. HSBC's motion is DENIED in all other respects. In addition, Defendant United's Motion to Dismiss (Document #73) is DENIED.

IT IS SO ORDERED, this 1st day of August 2006.

Footnote

1 The title of a novel by American author Joseph Heller, *Catch 22* has come into common use as a term describing a *double-bind* of any type, often the result of a rule that employs self-contradictory or circular logic. *Wikipedia*, http://en.wikipedia.org/wiki/Catch-22

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1:03-cv-1698-RLY-TAB
UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF INDIANA INDIANAPOLIS DIVISION

JAMES MCDONALD and KAREN MCDONALD,
Plaintiffs,

vs.

HSBC FINANCE CORPORATION and UNITED HEALTHCARE CORPORATION d/b/a UNITED HEALTHCARE INSURANCE COMPANY,
Defendants.

ENTRY DENYING MOTION TO RECONSIDER AND REAFFIRMING ENTRY DENYING DEFENDANTS' MOTIONS TO DISMISS WITH CERTIFICATION OF ENTRY AS APPEALABLE PURSUANT TO 28 U.S.C. § 1292(B)

On August 1, 2006, this court entered its order denying each of the defendants' dismissal motions, with the exception of any claim brought by Mrs. McDonald. In that entry the court noted that scholars and jurists have been debating the question of whether or not ERISA § 502(a)(3) allows for "make-whole" relief against fiduciaries of the sort being sought against by Mr. McDonald in this case. Since that entry, United Healthcare Corporation has filed a motion asking the court to certify its ruling for interlocutory appeal (Document # 92) and the other defendant, HSBC Finance Corporation, has filed a motion asking the

court to reconsider its August 1 st ruling (Document # 95). In both instances, the defendants have cited to recent decisions from other circuits which have found that money damages could not be obtained under § 502(a)(3). *See Coan v. Kaufman*, F.3d , 2006 WL 2075129 (2nd Cir. 2006); *LaRue v. DeWolff, Boberg Associates, Inc.*, 450 F.3d 570 (4th Cir. 2006). However, as well written and reasoned as those decisions are, they have not persuaded this court that the riddle is solved.

The riddle, as presented in this case (assuming the accuracy of the allegations at this stage), is as follows:

1. Plaintiff, a participant in a welfare benefit plan, suffered personal injury in the form of a stroke.

2. The defendant fiduciaries of the benefit plan violated the provisions of the plan, which contributed to the cause of plaintiffs injured health.

3. ERISA preempts any state law theory of recovery against the fiduciaries of a covered benefit plan.

4. Section 502(a)(3) of ERISA provides a participant with what has been described by the Supreme Court as a "catchall" provision or "safety net" to remedy any violation of its provisions, but the relief provided by that safety net is limited to "equitable relief."

5. The Supreme Court has construed § 502(a)(3) not to authorize an award of money damages against a non-

fiduciary, but the question of whether or not some form of "make-whole" relief may be pursued against a fiduciary remains unanswered. At least that is the view of the two justices who joined in a relatively recent concurring opinion, *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 223-224 (2004) and perhaps the Seventh Circuit panel that previously remanded this matter with a suggestion that plaintiff review that concurring opinion going forward. *See McDonald v. Household International, Inc.*, 425 F.3d 424, 430 (7th Cir. 2005).

6. QUERY: Should a plaintiff who has suffered personal injury be allowed to pursue "make-whole" relief, consisting of lost wages and impaired earning capacity, against a fiduciary whose violation of the terms of a benefit plan has contributed to cause that plaintiff's damage?

Plaintiff has responded to United Healthcare's motion and stated its agreement that the issue should be certified for an interlocutory appeal to the Seventh Circuit. The court, in its earlier entry, discussed the fact that courts have found that concerning ERISA Congress intended a careful balance between ensuring enforcement of a participant's rights and the encouragement of continued creation of such plans by employers. This court also acknowledged, the rather significant limitation courts have placed on recovery under § 502(a)(3), just as we now note the growing majority of appellate decisions opining that the Supreme Court's interpretation of § 502(a)(3) as it applies to nonfiduciaries would not differ with respect to fiduciaries. However, this court refused to dismiss the case at such an early stage because of the ongoing judicial debate over interpretation and intent of §

502(a)(3) and the possibility that plaintiff might prove some set of facts that would "squeeze" past the existing constrictions. What those facts might be is, at this point, beyond the court and apparently beyond the plaintiff as well. What remains is the debate, which is a question of law. And this court's earlier ruling denying the motions to dismiss has placed it, though perhaps not squarely, on the side which interprets § 502(a)(3) as allowing some form of "make-whole" relief against fiduciaries under the right circumstances.

Accordingly, Defendant United's Motion for Certificate of Appealability (Document # 92) is GRANTED. This court is of the opinion that its order of August 1, 2006 (Document # 91), supplemented by the discussion in this entry, involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of this litigation. It follows then that the Motion to Reconsider (Document # 95), filed by defendant HSBC Finance Corporation, is DENIED.

IT IS SO ORDERED, this 18th day of September 2006.

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief

(i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary

(A) to enjoin any act or practice which violates any provision of this subchapter, or

(B) to obtain other appropriate equitable relief

(i) to redress such violation or

(ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169 (a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021 (f)(1) of this title,

(A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or

(B) to obtain appropriate equitable relief

(i) to redress such violation or

(ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [1] or the

terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401 (a), 403 (a), or 405 (a) [2] of title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b (a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator

(A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 [2] of this title, section 1021 (e)(1) of this title, or section 1021 (f) of this title with respect to a participant or beneficiary, or

(B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021 (b)(4) [2] of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024 (a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021 (d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021 (e)(2) of this title with respect to any person or who fails to meet the requirements of section 1082 (d)(12)(E) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of section 1082 (b)(7)(F)(vi) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021 (g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024 (a)(6) of this title, the plan administrator fails to furnish

the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with section 1021 (i) of this title. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b–14 (c)(8) [2] of title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall

notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021 (f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in

any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate

provided under the plan, or, if none, the rate prescribed under section 6621 of title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975 (f)(4) of title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975 (f)(5) of title 26) within 90 days after notice from the Secretary (or

such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975 (e)(1) of title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518 (a) of title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or

violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax

imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056 (e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

1:03-cv-1698-RLY-TAB
UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF INDIANA INDIANAPOLIS DIVISION

JAMES MCDONALD and KAREN MCDONALD,
Plaintiffs,

vs.

HSBC FINANCE CORPORATION and UNITED HEALTHCARE CORPORATION d/b/a UNITED HEALTHCARE INSURANCE COMPANY,
Defendants.

PLAINTIFFS' SECOND AMENDED COMPLAINT

Comes now the Plaintiff, James McDonald, by counsel, and for his claim for relief against the Defendants alleges and says:

General Allegations

1. This case is brought pursuant to Title 28 U.S.C. § 1332(a), as the controversy involves citizens of different states, and the amount in controversy exceeds Seventy-Five Thousand Dollars ($75,000.00), exclusive of interest and costs.
2. That additionally, original jurisdiction of this matter rests with this Court pursuant to Title 29 U.S.C. §1132(e).
3. That at all times relevant herein, Plaintiffs James McDonald and Karen McDonald resided together as husband and wife at 19083 Stockton Drive, City of

Noblesville, County of Hamilton, State of Indiana. Plaintiffs James and Karen McDonald are citizens of Indiana.

4. That at all times relevant herein, HSBC Finance Coproation ("HSBC"),[1] is a Delaware corporation with its principal place of business located at 2700 Sanders Road, Prospect Heights, Illinois 60070. Defendant HSBC is a citizen of Illinois. Defendant HSBC is licenced to do business and does substantial business within the State of Indiana.

5. That at all times relevant herein, United HealthCare Corporation, d/b/a United HealthCare Insurance Company ("United Healthcare"), is a corporation incorporated under the laws of the State of Minnesota, with its principal place of business located at 300 Opus Center, 990 Bren Road East, Minnetonka, Minnesota 55343. Defendant United HealthCare is a citizen of Minnesota. Defendant United HealthCare is licenced to do business and does substantial business within the State of Indiana.

6. That on the 19th day of November, 2001, Plaintiff James McDonald began employment with Defendant, HSBC, at its office located at 111 East Congressional Blvd., City of Carmel, County of Hamilton, State of Indiana.

7. That Plaintiff, James McDonald, was promised insurance coverage, including prescription benefit coverage, through Defendant, HSBC Finance's Group Insurance ERISA Plan ("the Plan") with Defendant,

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[1]HSBC Finance Corporation is the renamed corporate entity resulting from the December 2004 merger between Household International, Inc. and Household Finance Corporation.

United HealthCare. (See United HealthCare Benefit Summary, attached hereto as Exhibit B)

8. That the Plan coverage included Plaintiff's prescription benefit coverage; specifically, the policy provided that the employee only pay a small copayment for prescription drugs purchased at a retail pharmacy. (See United HealthCare Benefit Summary, attached hereto as Exhibit B).

9. That at all times relevant hereto Plaintiff James McDonald complied with the terms and conditions of his employment and his eligibility for health insurance coverage under the Plan, including, but not limited to, the payment of premiums through paycheck deductions.

10. That pursuant to Plaintiff, James McDonald's November 16, 2001 employment confirmation letter, his insurance coverage was to be effective 30 days from his start date or December 19, 2001. (See Employment Confirmation Letter, attached hereto as Exhibit A).

11. That prior to November 19, 2001, Plaintiff James McDonald had been prescribed Vasotec, a prescription medication for his blood pressure.

12. That on and after the date of December 19, 2001, Plaintiff James McDonald repeatedly went to his pharmacy to get prescriptions filled, including his Vasotec blood pressure medication, and was told that the paperwork had not come through, and that he had no benefits under the Plan.

13. That Plaintiff, James McDonald, was unable to obtain his prescribed medication, Vasotec, because he was unable to pay for his medication without his insurance coverage. James McDonald went without his Vasotec medication from December 19, 2001 until January 15, 2002.

14. That after December 19, 2001, Plaintiff James McDonald made repeated requests to HSBC and to United Healthcare regarding his insurance benefit coverage, pleading for it to be activated.
15. That on January 15, 2002, nearly one month after his insurance coverage was to become effective, Plaintiff, James McDonald suffered a catastrophic hypertensive intercerebral hemorrhagic stroke.

COUNT I. Relief Under the Employee Retirement Income Security Act ("ERISA")

16. Plaintiffs reallege and reassert the material allegations contained in rhetorical paragraphs one (1) through thirteen (13) and includes them herein by reference.
17. That Defendants, HSBC and United HealthCare, individually and jointly owed the Plaintiff, James McDonald, fiduciary obligations related to the ERISA benefits at issue.
18. That Defendants, HSBC and United HealthCare, individually and jointly breached their fiduciary obligations related to the ERISA Plan benefits at issue.
19. That Mr. McDonald is currently a participant in the Plan, and Defendants have provided all benefits pertaining to Mr. McDonald's incurred medical expenses which may be due under the Plan as of the date of the motion for leave to amend.
20. That as a result of Defendants' breach, Plaintiffs are entitled to "make-whole" relief under ERISA, including, but not limited to the redress of:

a. James McDonald's lost wages;
b. James McDonald's impaired earning capacity;

WHEREFORE Plaintiffs pray for judgment against Defendants, HSBC and United HealthCare to obtain relief pursuant to ERISA and for all other relief just and proper in the premises.